Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clive McKenzie a prisoner at HMP Woodhill on 20 February 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr McKenzie was found unresponsive and died in his cell on 20 February 2016 at HMP Woodhill. The cause of his death was given as “recreational drug use” which had caused a fatal cardiac arrhythmia. He was 50 years old. I offer my condolences to Mr McKenzie’s family and friends.

Mr McKenzie was only in Woodhill for four days before he died. He had a history of depression and substance misuse and received appropriate treatment from the mental health and substance misuse teams. However, I am concerned at the apparent availability of illicit drugs at Woodhill and that, when staff suspected Mr McKenzie might have used them two days before he died, they did not seek medical advice, contrary to the prison’s local protocol. Despite this omission, staff had little reason to be concerned about Mr McKenzie the day before he died and it would have been difficult for them to have predicted or prevented his death.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2017**

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Summary

Events

1. On 15 February 2016, Mr Clive McKenzie was sentenced to eight months imprisonment and arrived at HMP Woodhill. Mr McKenzie told a reception nurse

that he had a history of depression and substance misuse. A doctor prescribed Mr McKenzie antidepressants and medication to help him manage the symptoms of withdrawal from drugs.

2. The next day, Mr McKenzie told staff from the substance misuse team that he used heroin and crack cocaine every day, and spice, a New Psychoactive Substance, three or four times a month. The doctor prescribed methadone (a synthetic opioid used to treat heroin addiction).

3. On the evening of 17 February, Mr McKenzie was aggressive and argumentative, and was slurring his words and unsteady on his feet. An officer said that he alerted his supervising officer, who visited Mr McKenzie and concluded that he did not need to be assessed by a nurse. The supervising officer did not remember having had any direct contact with Mr McKenzie that evening. The officer submitted a security report that prisoners had said spice was available on the wing, and that this might have explained Mr McKenzie's behaviour. No further action was taken in response.

4. On 18 February, a GP agreed to increase Mr McKenzie's methadone dose. A nurse dispensed Mr McKenzie his methadone on 19 February and had no concerns about him or that he was under the influence of illicit substances.

5. At 5.30am and 6.56am on 20 February, staff carried out routine checks and thought that Mr McKenzie was asleep. At 9.09am, an officer unlocked Mr McKenzie's cell, but found him unresponsive and shouted for help. Another officer raised the alarm and staff arrived and began resuscitation. At 9.25am, the paramedics arrived and continued resuscitation attempts. Sadly, they were unsuccessful and, at 9.48am, they recorded that Mr McKenzie had died. The post-mortem report concluded that Mr McKenzie died as a result of recreational drug use which had caused a fatal cardiac arrhythmia.

Findings

6. We found that staff did not seek healthcare advice when they suspected Mr McKenzie was under the influence of drugs on 17 February, contrary to the local policy. Despite this omission, we found no evidence to suggest that Mr McKenzie's behaviour or presentation should have caused concern on 19 February and, accordingly, it would have been difficult for staff to have predicted or prevented his death.

Recommendations

- The Governor should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of relevant extracts from Mr McKenzie's prison and medical records.

9. The investigator interviewed eleven members of staff at HMP Woodhill in April and May 2016.

10. NHS England commissioned a clinical reviewer to review Mr McKenzie's clinical care at the prison. The clinical reviewer participated in interviews with healthcare staff.

11. We informed HM Coroner for Milton Keynes of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr McKenzie's brother and ex-partner to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond.

Background Information

HMP Woodhill

13. HMP Woodhill has a dual role of a local prison and a high security prison and can hold more than 700 men. Central and North West London NHS Foundation Trust provides health services at the prison. Westminster Drug Project provides drug and alcohol support services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Woodhill was in September 2015. Inspectors found that not all prisoners needing opiate substitution treatment or alcohol detoxification were located on the stabilisation unit on their first night, and some were located on the first night unit, which did not have 24 hour nursing care. The management and supervision of methadone administration were found to be poor. Drug availability was lower than in other prisons, although Inspectors noted the prison needed to be alert to the increasing availability of New Psychoactive Substances such as spice.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2015, the IMB reported that HMP Woodhill was a complex establishment that was challenging to manage. The Board noted the problems caused by the rise in prisoners' use of new psychoactive substances.

Previous deaths at HMP Woodhill

16. In 2016, there have been nine apparently self-inflicted deaths and three deaths from natural causes at HMP Woodhill. There were no significant similarities with the circumstances of the other deaths.

New Psychoactive Substances (NPS)

17. NPS are an increasing problem across the prison and immigration detention estates. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.

18. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.

19. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm.

The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

20. On 15 February 2016, Mr Clive McKenzie arrived at HMP Woodhill after he was sentenced to eight months imprisonment for breaching an anti-social behaviour order and a suspended sentence. This was not his first time in prison.

21. Mr McKenzie's Person Escort Record (which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) noted that he was prescribed medication for depression.

22. At 7.35pm, Nurse A, assessed Mr McKenzie in reception. He noted Mr McKenzie's history of depression and substance misuse, and that he had recently used heroin and cocaine. The nurse recorded that Mr McKenzie had no thoughts of suicide or self-harm, and referred him to the substance misuse team and to the GP.

23. Dr A, saw Mr McKenzie shortly after. The doctor told the investigator that his role in reception in the evenings was to assess prisoners coming into the prison, and prescribe medication to help them manage drug and alcohol withdrawal symptoms until they saw the substance misuse team in the morning. Mr McKenzie said that he regularly used heroin and crack cocaine and the doctor prescribed medication to relieve his withdrawal symptoms, including anti-anxiety medication, ibuprofen, and medications to help Mr McKenzie sleep and to relieve stomach cramps. The doctor also prescribed sertraline (an antidepressant medication). He said that the substance misuse team was responsible for prescribing appropriate opiate substitutes, such as methadone, after assessing prisoners. Mr McKenzie spent his first night on the Induction Unit.

24. On the morning of 16 February, Mr McKenzie saw Dr B and Nurse B, from the substance misuse team. Mr McKenzie told them that he had started using drugs eighteen months earlier and smoked heroin every day, the last time being two days earlier. Mr McKenzie also said that he smoked spice (a New Psychoactive Substance) three to four times a month. The doctor noted that Mr McKenzie had a history of seizures from spice misuse.

25. Mr McKenzie's urine tested positive for cocaine, opiates and benzodiazepines. Dr B assessed Mr McKenzie's heroin withdrawal symptoms using the Clinical Opiate Withdrawal Scale and noted that he had moderate withdrawal symptoms. The doctor prescribed Mr McKenzie a starting dose of 20mls of methadone and referred him for a mental health assessment.

26. Mr McKenzie told Dr B he should not share a cell because he was a violent person and was carrying a small blue pen as a weapon to defend himself. Mr McKenzie agreed to give the doctor the pen to avoid any incident. The doctor told the Induction Unit supervising officer, and officers spoke to Mr McKenzie about the incident. Mr McKenzie said that another prisoner in the Induction Unit had been spreading rumours about him. Staff told him that he would be moving to the Drug Rehabilitation Unit after lunch, but Mr McKenzie said he wanted to stay away from other drug users. Later that day, Mr McKenzie moved to a single cell on a standard residential wing.

27. That afternoon, Nurse C, from the mental health team, noted that she was unable to assess Mr McKenzie because he was not in his cell.

28. On the morning of 17 February, a mental health nurse, Nurse D, carried out Mr McKenzie's routine mental health review. Mr McKenzie said that he had a family history of mental health issues but did not want to discuss it. The nurse recorded that Mr McKenzie's presentation was strange and he did not engage very well during the assessment. She told investigators that Mr McKenzie was quiet, showed symptoms of drug withdrawal and looked physically uncomfortable. Mr McKenzie told the nurse he was taking medication for his depression, had no current concerns about his mental health, and did not have any thoughts of suicide or self-harm. The nurse said that she did not think he needed any further mental health assessment at that time and told Mr McKenzie to speak to the GP if he had any concerns in the future.

29. Later that morning, Mr McKenzie appeared at court via video link and was charged with theft and failure to surrender to the police. He was sentenced to two twelve month conditional discharges to run concurrently and received fines totalling £120.

30. That afternoon, Nurse E carried out Mr McKenzie's secondary health screening. The nurse told investigators that Mr McKenzie was very coherent and she did not suspect that he had taken any illicit substances. She also carried out a short mental health assessment which indicated that Mr McKenzie had no mental health problems.

31. At around 6.00pm, Mr McKenzie went to the wing office and told Officer A that he had not received his evening meal. The officer said that Mr McKenzie was angry and shouted at him. He told Mr McKenzie that the kitchen was closed, but that he would try to get him some cereal and milk. The officer said that, although Mr McKenzie seemed happy with this, he continued to argue and threatened not to return to his cell that evening.

32. Officer A said that he persuaded Mr McKenzie to walk back to his cell and locked the door. The officer said that at sometime between 6.00pm and 7.00pm, Supervising Officer (SO) A, came onto the wing and the officer told him about Mr McKenzie's behaviour. The officer said that the SO and another member of staff went to Mr McKenzie's cell and gave him the cereal. Officer A said that the SO spoke to him after seeing Mr McKenzie and commented that he had a lot of medication in his cell. The officer said that he and the SO agreed that this might explain why Mr McKenzie had been slightly unsteady on his feet earlier. The officer noted in Mr McKenzie's prison record that the SO had seen him and had no particular concerns and did not think that healthcare staff needed to attend.

33. When the investigator spoke to SO A, he said that he did not remember seeing or speaking to Mr McKenzie that evening. He said that he may have brought some cereal onto the wing, and may have been outside a cell when this were given to a prisoner, but was not sure if this was Mr McKenzie's cell. The SO said that, although he did not remember Mr McKenzie, if he had been concerned about him, he would have asked a nurse to assess Mr McKenzie and would have asked them to remove any medication from his cell.

34. Officer A submitted a security intelligence report, noting that Mr McKenzie had become argumentative, was slurring his words, was unsteady on his feet and had been escorted back to his cell. The officer noted that other prisoners had mentioned that spice was available on the wing and he wrote that this might explain Mr McKenzie's behaviour. There is no evidence that staff took any further action in response to this report.

35. In October 2015, the Governor issued a Staff Information Notice on spice, which gave instructions on what to do if they suspected a prisoner to be under the influence of illicit drugs. The notice instructed staff to put the prisoner in his cell, tell a supervising officer, and ask a nurse to come and assess the prisoner. Staff should also check the prisoner every fifteen minutes (until they get further advice from healthcare staff), submit an intelligence report, and make a note in the prisoner's record. While Officer A completed some of the requirements in the notice, he did not contact healthcare staff or regularly observe Mr McKenzie.

36. On 18 February, Mr McKenzie told Dr C that the 20ml dose of methadone was not enough and that he was still experiencing withdrawal symptoms. The doctor increased that day's methadone dose to 30ml and the following day's to 40ml. The doctor noted he would review Mr McKenzie in four weeks.

37. On the afternoon of 19 February, Nurse F gave Mr McKenzie his methadone. She said that she did not notice anything unusual about his behaviour or presentation.

Events of 20 February

38. At 5.30am on 20 February, Officer B carried out a routine check of all of the prisoners on the wing. At 6.56am, Officer C carried out another routine check. CCTV footage showed both staff checking Mr McKenzie's cell by looking through the observation hatch, and neither raised any concerns about Mr McKenzie that morning. According to local ambulance service records, both thought that Mr McKenzie was asleep.

39. At 9.09am, Officer D unlocked Mr McKenzie's cell so that he could collect his medication. The officer went into the cell and saw Mr McKenzie lying on his back in his bed. She called Mr McKenzie's name but he did not respond, so she shook his leg and called his name again. The officer noticed that Mr McKenzie had a white foam substance coming from the left side of his mouth. She tried to rouse him again, and looked at his chest but could see no sign that he was breathing. She checked his neck for a pulse but could not find one, so shouted for other staff to help.

40. Officer A was working on the wing and heard Officer D call out, so he ran up to Mr McKenzie's cell with Officer E. Officer A went into the cell and shook Mr McKenzie's shoulder, but he did not respond. At 9.11am, Officer A radioed a code blue (which indicates a prisoner is unconscious or not breathing) and control room staff immediately called an ambulance. Officer C and Officer F also arrived at Mr McKenzie's cell and Officer F started trying to resuscitate Mr McKenzie.

41. Nurse F and a pharmacy technician responded to the code blue and arrived at Mr McKenzie's cell very quickly. Nurse F checked Mr McKenzie for signs of life and found none. The nurse and healthcare colleagues took over the resuscitation efforts. She attached a defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest), but it found no shockable heart rhythm and advised staff to continue resuscitation.

42. At approximately 9.25am, the paramedics arrived at Mr McKenzie's cell and continued to try to resuscitate him. At 9.48am, they recorded that Mr McKenzie had died.

Contact with Mr McKenzie's family

43. At around 12.30pm, two prison family liaison officers went to Mr McKenzie's ex-partner's home and told her that he had had died. They offered condolences and support. The prison contributed to the costs of Mr McKenzie's funeral, in line with national guidance.

Support for prisoners and staff

44. After Mr McKenzie' death, a prison manager and the duty governor debriefed the staff involved in the emergency response. The prison's care team offered support. The Governor issued notices to staff and prisoners informing them of Mr McKenzie' death.

45. The prison posted notices informing other prisoners of Mr McKenzie's death, and offering support. Officers and members of the chaplaincy team supported prisoners on Mr McKenzie's wing. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr McKenzie' death.

Information received after Mr McKenzie's death

46. The Head of Security said that after Mr McKenzie's death, staff received information that Mr McKenzie was a regular spice user and had been supplied spice by another prisoner on the wing. On 23 February, a member of staff submitted a security intelligence report noting that another prisoner had said that Mr McKenzie had been storing his medication to take an overdose. Three days later, on 26 February, a member of staff submitted a security intelligence report that there was further intelligence suggesting Mr McKenzie had talked about enjoying smoking spice.

Post-mortem report

47. The post-mortem gave the cause of Mr McKenzie's death as recreational drug use, which most likely precipitated a sudden cardiac arrhythmia (irregular heartbeat) and death. The toxicology report found methodone in Mr McKenzie's blood in line with therapeutic use.

Findings

Managing Mr McKenzie's substance misuse

48. Mr McKenzie had only been at Woodhill for five days when he was found unresponsive in his cell. The cause of his death was found to be recreational drug use, leading to a fatal cardiac arrhythmia. On his arrival, Mr McKenzie told staff that he had a history of substance misuse, including daily use of heroin and crack cocaine and intermittent use of spice (an NPS). He was prescribed methadone and the dose was appropriately increased when he complained of withdrawal symptoms.

49. On 17 February, staff thought that Mr McKenzie was behaving strangely and seemed unsteady on his feet. Security reports submitted that day suggested that at least one officer thought he might have used illicit substances, in particular spice, and noted that other prisoners had reported that spice was readily available on the wing. After Mr McKenzie died, staff submitted further security reports indicating that Mr McKenzie had used spice at Woodhill and that other prisoners on the wing had supplied the drug to him.

50. We are concerned that staff did not act in line with Woodhill's local policy on dealing with prisoners who may have used spice. A local staff information notice issued in October 2015 instructed staff who suspected a prisoner was under the influence of illicit drugs to put the prisoner in his cell, tell a supervising officer and ask a nurse to assess the prisoner. The notice stated that wing staff should not try to diagnose the condition of the prisoner or make assumptions about the cause. It instructed staff to check the prisoner every 15 minutes until they had been assessed by healthcare staff.

51. Officer A told the investigator that, although he did not think that Mr McKenzie required any assistance, he returned him to his cell and notified his supervising officer, SO A. He said that SO A decided that Mr McKenzie did not need to be assessed by healthcare staff. SO A had no recollection of any direct contact with Mr McKenzie that evening. Staff should have notified healthcare as soon as they had any concerns that Mr McKenzie was under the influence of an illicit substance and should have monitored his condition regularly until they had received healthcare advice. We make the following recommendation:

    The Governor should ensure that staff consistently follow a clear pathway for managing prisoners suspected of using NPS and other illegal substances.

52. However, despite this omission, we found little evidence to indicate that Mr McKenzie's presentation or behaviour on 19 February gave staff any reason for concern. In these, circumstances, we consider it would have been difficult for staff to have predicted or prevented his death.

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